AN EPITOME

OF THE

VENEREAL DISEASES.

PRINTED BY
H. K. LEWIS, GOWER STREET, LONDON.

AN EPITOME

OF THE

VENEREAL DISEASES

BEING

A SUCCINCT ACCOUNT OF THE WELL ESTABLISHED AND MORE IMPORTANT FACTS RELATING TO THESE DISEASES.

Designed for the use of Students attending Hospital Out-patient Practice.

PRESENTED BY THE AUTHOR.

BY

ALEXANDER BRUCE, M.S., B.Sc., Lond.

FELLOW OF THE ROYAL COLLEGE OF SURGEONS;
ASSISTANT SURGEON TO THE WESTMINSTER HOSPITAL;
AND LECTURER ON ANATOMY IN THE MEDICAL SCHOOL.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

LONDON:
H. K. LEWIS, 136, GOWER STREET.
1868.

Digitized by the Internet Archive
in 2016

https://archive.org/details/b22358328

The object of the following pages is to present to the student the more important facts relating to the clinical history of the venereal diseases, with only brief references to the points still undetermined, in order that his attention may be directed to the essential features of the cases under observation, and not be distracted by the contradictory statements of controversialists. The progress and characters of the constitutional affections have been only shortly indicated, as the protæan forms of the syphilides cannot be both accurately and briefly described, whilst the observation of a few cases will give the student a better idea of their character than he can possibly obtain from any mere verbal description.

AN EPITOME

OF THE

VENEREAL DISEASES.

Gonorrhœa.

Gonorrhœa (from γονη semen, ῥοη flow; vulg. the clap, Eng.; la chaudepisse, Fr.; der tripper, Germ.;) is a highly contagious affection produced by the application of a specific animal poison to a mucous surface (generally that of the genito-urinary tract), and accompanied by acute inflammation and a very copious mucopurulent discharge: though primarily a purely local disease it is not unfrequently followed by symptoms of a general or constitutional character.

The virus of Gonorrhœa is entirely distinct from that of syphilis and neither of them can produce the other; the two diseases may however be contracted at the same time as the poisons may co-exist in the same individual. It is probable that the poison of gonorrhœa may be produced *de novo*, but in consequence of the extreme persistence of the contagion in some cases there is considerable doubt on this subject.

The parts usually affected are,—

(*a*) in the male;—the urethra, primarily the the anterior part of the penile portion, subsequently the posterior and bulbous part; less frequently the membranous and prostatic portions. The inflammation, may, however, though rarely, extend back into the bladder. Sometimes also it affects the external surface of the glans and prepuce.

(*b*) in the female;—the vulva and vagina, the os and cervix uteri, and even the urethra. The two first mentioned parts suffer primarily and most frequently; the disease however lasts longest and is liable to become chronic at the upper part of the vagina, and at the os and cervix uteri.

Symptoms and Progress.—

Incubation; usually about 3 days, varying however from 24 hours to 5 days, very rarely delayed till the 8th day.

1st Stage, *Irritation,* lasts from 1 to 2 days. Heat and itching with redness and swelling of the urethral orifice, with slight glairy discharge.

2nd Stage, *Acute Inflammation,* lasts from 14 to 20 days. More or less general fever; pain in affected parts, considerable and constant; frequent desire to pass water, which gives rise to scalding pain and difficulty in its passage; penis swollen especially about the glans, so as to render retrac-

tion of the foreskin difficult; urethra tender, thickened and cord-like, especially about the region of the bulb; sometimes deep pain in the perineum; chordee at night. Discharge abundant, thick and purulent.

3rd Stage, *Subacute and Subchronic;* duration uncertain, from 14 days onwards. General feeling of exhaustion with dragging pains in penis and scrotum. Less pain and scalding during micturition; less inflammatory swelling about the glans, but greater thickening in deep parts of urethra; less tenderness. Discharge less abundant and thinner in character.

4th Stage, *Chronic Gleet;* there is no marked distinction beween this stage and the preceding one, the disease however can hardly be said to have degenerated into a gleet until 8 weeks from the commencement, and it is often later than this. There is always some general narrowing of the urethral canal with more or less local stricture due to thickening of the submucous tissue. The mucous membrane of the tract is of an ash grey colour. The discharge often amounts only to a slight moisture and is muco-purulent. The disease is probably communicable at this stage.

Complications (*a*) Local and (*b*) Remote.—

(*a.*) *Phimosis,* resulting from a natural tightness of the preputial orifice, and great swelling

of the glans penis during the 2nd stage; often attended by excoriation of the corona glandis the result of the irritation caused by the retention of the secretions of the part.

Chordee, painful erections at night accompanied by a twist in the body of the penis, caused by the agglutination of the tissue of the corpus spongiosum preventing the organ assuming its its natural form.

Other complications, only seen in severe cases, are irritability and spasm of the neck of the bladder, retention of urine, hæmorrhage from urethra, abscess in the prostate.

(*b*) *Bubo,* enlargement of the glands of the groin with great tendency to become acutely inflamed and to suppurate if irritated. In the majority of cases the enlargement is unimportant and does not lead to suppuration.

Inflammation of the testicle and epididymis, occuring either by metastasis on the sudden cessation of the discharge, or by the inflammation gradually passing along the cord. As a rule only one testis is affected at once.

Inflammation of the conjunctiva (Gonorrhœal Ophthalmia), highly contagious, probably the result of direct contact of the pus with the mucus membrane. Very acute and destructive, in consequence of the occurrence of intense chemosis causing sloughing of the cornea.

Sequelæ of Gonorrhœa.—

Stricture, organic, generally the result of prolonged or repeated attacks; probably always present to some extent in cases of chronic gleet.

Warts, chiefly on the glans and prepuce, generally the result of phimosis and want of cleanliness.

Pain in testicle and cord, of neuralgic character.

Constitutional Affection.

1. Rheumatic affections of the fibrous tissues, especially of the sheaths of the muscles, the eye and the testis; gonorrhœal rheumatism, sclerotitis and orchitis.

2. Eruptions of an erythematous and roseolous character on the skin and mucous membrane of the fauces.

Principles of Treatment.—

Acute stage. Antiphlogistic; free purgation, alkaline drinks with henbane or opium, warm application to the parts, leeches to the perineum if necessary. Absolute rest, and mild diet without stimulants.

Sub-acute and sub-chronic stage. Copaiba or cubebs with alkalies; injections cautiously used at first, gradually more freely.

Chronic stage. Iron and quinine, mineral acids and more liberal diet. Stronger injections may be used, and a silver catheter occasionally passed; Salt baths.

Constitutional Affections. Iodide of Potassium, iron, quinine, cod liver oil. Hot baths. Change of air.

NOTES.

Gonorrhœa. In women the general symptoms are often very imperfectly developed; there is a copious yellowish discharge from Vulva and Vagina, but comparatively little pain or constitutional disturbance. The glandular affection is generally slight, and rarely leads to suppuration. The discharge from the os and cervix uteri frequently continues for a very long period, and as it is uncertain how long it retains its power of propagating the disease, it is imposible to consider a woman free from suspicion as long as this discharge continues.

A catarrhal condition of the mucous membrane of the os and cervix uteri is often established in women admitting too free sexual intercourse, as the result of long continued excitement and irritation, but not necessarily connected with gonorrhœal infection.

Amongst many questions relating to this subject which await further investigation, the following may

be cited as indicating objects to which clinical study may be usefully directed.

1. Origin. Is there any evidence that the disease originates *de novo* from an unhealthy condition of the male or female secretions as the result of sexual intercourse ?

2. Contagion. At what stage, or under what condition do the secretions become incapable of communicating the disease ?

3. Gonorrhœal Conjunctivitis. Is the so called gonorrhœal ophthalmia invaribly the result of direct application of the specific poison to the surface of the conjunctiva, or is it dependent upon the constitutional affection of the individual ?

4. The relation existing between the persistence of gonorrhœa and the formation of stricture.

5. Is the constitutional affection in any way dependant on the degree to which the glands are implicated in the primary disease, and is it influenced by the duration, or the frequency of the attacks ?

THE NON-INFECTING VENEREAL SORE.

The simple soft and Phagedæmic Chancre—(Chancre Fr.; Schanker, Germ.); An ulcer produced by the contact of a specific poison derived from a similar sore with a broken surface of skin or mucous membrane (usually of the sexual organs) or by direct innoculation of the poison into the cellular tissue.

The virus from a soft chancre always reproduces a similar sore, never gives rise to any other form of venereal disease, and is entirely distinct from the poison of syphilis.

The parts usually affected are

(*a*) in the male; the glans penis, especially the corona glandis; the prepuce; the frænum; the orifice of the urethra or the canal itself.

(*b*) in the female; the vulva, especially the furchette; the nymphae; rarely the vaginal wall, but not unfrequently the os uteri.

The sores may also be found in exceptional situations, as the lips, fingers, &c.

Development. Within a period of 24 to 48 hours (very rarely longer than 3 days) after innoculation a pustule appears at the spot, over which a scab forms, which on separating leaves a small rounded

ulcer; this continues to increase until when fully developed it presents the following characters.

Form. Irregularly rounded or oval, very shallow.

Edges. Sharply defined, as if cut with a punch, slightly undermined, freely moveable on subjacent tissues. and surrounded by a slightly red or purplish areola.

Floor. Irregular, worm-eaten or spongy, covered with an abundant greyish pus and a little slough: it can be easily pinched up from the tissues on which it lies.

There is no thickening or induration around or beneath the ulcer, unless the parts have been irritated by caustic or friction; when it does occur, it is simply inflammatory, and shades off into the surrounding parts without any defined limit. It is often difficult to distinguish between this inflammatory induration and that characteristic of the hard chancre.

Progress and Tendencies.

The ordinary soft chancre is slow to heal, and has a tendency to spread by erosion of its edges; its average duration is from about 4 to 6 weeks. It may become phagedæmic at any period; this process being indicated either by the formation of deep sloughs, or by the rapid erosion of the edges and the destruction of surrounding parts. The

formation of the ulcer is always attended by some pain and itching in the part, and sometimes by very considerable inflammation and swelling of the glans penis, often leading to phimosis in individuals with a tight prepuce. The granulations covering the surface of the sore, when it begins to heal, are apt to become soft and fungating, and may become irritable and painful. When granulation is fully established the pus is not innoculable.

The resulting cicatrix is at first thin and liable to break down, but subsequently presents no special characteristic, and is never indurated.

In consequence of the highly contagious nature of the secretion these ulcers are rarely single, and may be very numerous. They constitute the form of veneral sore most commonly met with, being at least four times as numerous as the hard variety.

Affection of the Glands in the Groin.—Suppurating Bubo is by no means a necessary consequence of the disease. Usually only one set of glands becomes inflamed; the affection may be one of two varieties.

1st. Simple enlargement due to irritation; this readily subsides if attended to sufficiently early: if an abscess forms the pus is *not* innoculable.

2nd. Specific enlargement of the glands due to

absorption of the poison from the chancre: this probably always leads to suppuration, the pus being innoculable and producing a primary sore. This affection of the glands occurs usually about the 3rd week.

The disease produced by the innoculation of pus from a soft chancre is purely local, or at most does not extend beyond the first set of lymphatic glands; it is followed by no secondary or constitutional symptoms, and confers on the individual no immunity from the effects of subsequent innoculations. Persons the subjects of syphilis are just as obnoxious to this disease as others.

Principles of Treatment.

At an early stage the poison may be destroyed by the thorough application of caustics or the cautery. The wound is then to be treated on ordinary principles: the pus is not innoculable.

At a later stage the ulcer should be dressed with black wash, or astringent lotions; the accompanying inflammation to be subdued by rest and warm applications.

General treatment, mild antiphlogistic remedies, saline purgatives, and moderate diet at first, followed by tonics and more liberal diet.

If phagedæma occur, the sloughing surface is to be destroyed with strong nitric acid or the cautery, and the patient treated with Iron and Quinine, and generous diet.

SYPHILIS.

Syphilis (origin of the word doubtful) is a general or constitutional disease produced by the direct innoculation of a specific poison from an infected individual, or by indirect transmission to the fœtus from an infected parent. It usually appears primarily in the form of the infecting Venereal Sore.

The hard or Hunterian Chancre.—An ulcer produced by the application to an abraided surface, or by the direct innoculation beneath the skin of a specific poison, derived either from a similar sore or from the secretions of some of the secondary forms of the disease.

It is usually situated—

(*a*) In the male; on or behind the glans, and on the prepuce, but rarely within the urethra.

(*b*) In the female, on the labia; it is frequently imperfectly developed on the vaginal wall, where the induration is not easily recognized if it exists.

Development. The period of incubation is prolonged and uncertain, being variously stated at from 5 to 28 days, usually probably from 14 to 21 days; a small hard red papule then appears, which soon ulcerates and assumes the following characters.

Form, rounded.

Edges, not well defined, sloping down to the base of the ulcer, hard and closely adherent to the surrounding tissues.

Floor, smooth and glazed, covered with a scanty pus which forms a plastic or semi-membranous layer on the surface; the base of the ulcer cannot be pinched up from the subjacent tissue.

The induration is marked and characteristic; it is well defined both beneath and at the margin, and never shades off into the surrounding tissue. It differs from simple inflammatory induration in its early development and persistence, and in its more defined limits and greater density.

Progress and Tendencies. The ulcer once fully formed is indolent, shewing very little tendency to increase and rarely becoming phagedenic. It heals by the formation of a thin cuticle or pellicle on its surface, but wtihout undergoing granulation. The induration remains for a very long period, and rarely disappears in less than 60 to to 80 days, in some cases lasting for years. There is very little pain or inflammation accompanying the sore, but the patient generally expresses himself as feeling ill and depressed without however any very distinct symptoms. The secretions from the surface of the ulcer or from the indurated cicatrix will at all times reproduce the disease

in a person not previously innoculated, but are innoculable with difficulty on the individual himself, and are incapable of reproducing the same characteristic sore. As a consequence of this the ulcer is usually single and when multiple the sores have probably commenced at the same period. The hard chancre occurs less frequently than the soft in the proportion of about 1 to 4.

Affection of the Glands in the Groin.—Indurated Bubo, invariably follows very shortly after the appearance of induration round the sore. It consists of a painless and indolent swelling giving rise to a characteristic hard or shotty feel; there are always several glands implicated and usually on both sides. There is no tendency to inflame or suppurate except as a result of extreme irritation.

The induration of the glands forms the most important element in making the diagnosis of the character of the primary sore, aud not unfrequently remains long after the disappearance of all mischief at the original seat of the disease.

Constitutional Syphilis shows itself in the development of certain characteristic affections of the skin and mucous membranes, the fibrous and osseous tissues, and of the Viscera; these are roughly classed according to the period at which they appear, into secondary and tertiary forms. The pa-

tient has the characteristic appearance of syphilitic cachexia, the countenance is depressed, the skin is of an opaque, dull, earthy look; there is loss of flesh and sometimes loss of hair, and a peculiar husky hoarseness in the voice, noticeable even when there is no distinct laryngeal affection. The syphilitic diseases of the skin are peculiar in their distribution and progress, and in their want of well defined characters; they usually leave some permanent mark of a more or less coppery tint. The order of the occurrence of these specific diseases may be stated as follows, although it must not be supposed that they will probably all occur in the progress of any one case, or that they necessarily follow precisely the same order.

	Skin.	Mucous Membranes and other Organs.
1st Period.	Rose Rash leaving coppery stains. Papular and Scaly eruptions. 1st appearance.	Sore Throat.
2nd Period.	Papular and Scaly eruptions. 2nd appearance. Mucous Tubercles and Condylomata. Pustular and Vesicular (rare) eruptions; rupial and ecthymatous forms.	Ulcerated Sores in Fauces and mouth. Laryngitis. Iritis. Loss of Hair. Periostitis.
3rd Period.	Serpiginous and Lupoid Ulcerations. Tubercular Syphilides.	Necrosis and Caries of Bones. Destructive Ulcerations of Larynx, Palate, and Nose. Disease of deep structures of Eye (choroid &c.). Diseases of Muscle, and the Viscera, formation of gummy Tumours.

Principles of Treatment.

It is useless to attempt to destroy the poison by caustics applied to the surface of the sore; the fact of the induration having taken place shews that the disease has become constitutional.

1st Period, *Primary Sore, &c.*

Mercury (as Iodide &c.) in pill with opium or henbane until the gums are slightly affected; this condition to be maintained for a short period, and to be combined with mild unstimulating diet and moderate rest. The sore to be dressed with black wash.

2nd Period, *Early Secondary Symptoms.*

Repeat the mercury cautiously either in the form of pill, vapour bath or inunction; subsequently employ Iodide of Potassium, which must be used with caution after the mercury: otherwise it may produce inconvenient salivation.

Liberal diet and moderate exercise.

3rd Period, *Later Secondary and Tertiary Symptoms.*

Mercury, in the soluble form (Bi-chloride) with tonics. Iodide of Potassium, Iron, Cod liver Oil. Generous Diet. Local ulcerations may be treated with ointments of the Nitric Oxide or Biniodide of Mercury, or by the cautery.

Hereditary Syphilis.

Syphilis may be transmitted to the fœtus from either parent. If the taint be strong the fœtus will probably not arrive at maturity, and miscarriage may result; in all cases therefore of repeated miscarriage the possibility of syphilis should be borne in mind.

A child affected with syphilis is usually small and sickly, and usually about the 4th or 6th week shews some evidence of its inherited cachexia. Skin rough, dull, opaque; body small and ill-nourished, with a pinched, shrivelled look. Picking of the nose and snuffling commences early, followed by sores about the mouth, and papular or tubercular eruptions around the anus and external genitals, which latter are often covered with erythematous patches. A scaly and fissured condition of the palms of the hands and soles of the feet is not unfrequently seen.

The temporary teeth are irregular, of a bad colour, and soon break down, but do not present any character of diagnostic value.

The permanent teeth are generally small, stunted and peggy in form, of a bad colour; the central incisors are deeply notched. This forms a most important diagnostic mark.

Subsequently the child will be liable to a specific form of inflammation of the cornea (interstitial keratitis), often accompanied by deafness; to periostial inflammation, and to special diseases of the liver and kidney with the formation of gummy tumours.

Principles of Treatment.

Mild mercurial course; Hydrargyrum cum creta in small doses, or Inunction of Unguentum Hydragyri, followed by Vinum Ferri and Cod liver oil.

In the later stages, Bichloride of Mercury, or Iodide of Potassium.

NOTES.

After the above brief summary of the progress of a simple uncomplicated case of syphilis, the facts relating to which are for the most part well established, it becomes necessary to consider some of the differences which exist amongst observers on this subject. Formerly a controversy raged concerning the relations existing between syphilis and gonorrhœa; then arose the question of the unity or duality of the poisons producing the hard and the soft chancre, which may now be considered as settled in fa-

vour the dualist party. The evidence of the existence of two distinct poisons, one producing local and the other producing constitutional effects, appears to be overwhelming, and almost every syphilographer of eminence has given in his adhesion to this view. To understand rightly the difficulty of arriving at the truth of this question it is necessary to consider certain complex cases, which may present thenselves.

1. A patient may contract a gonorrhœa and a chancre (either soft or indurated) at the same time, in which case each disease would run its own course; but should the chancre be urethral and not have attracted attention, the individual might affect others with a disease from which he himself might be apparently free.

2. Both varieties of chancre may co-exist in the same individual.

The following supposed case will illustrate what may occur. A woman having a hard chancre or mucous tubercles has connection with a man previously free from syphilis, who thereupon becomes affected; she subsequently has connection with an individual having a soft chancre but unsyphilized, he contracts syphilis, she a soft chancre; still later she admits a third individual already the subject of syphilis, who consequently becomes affected with a soft chancre only.

3. A hard chancre innoculated with pus from a soft chancre takes on some of the characters of the latter without however losing its characteristic in-

duration, thus forming a mixed chancre, which would be capable of propagating either form of disease according to the depth from which the secretion might be obtained.

4. The poison from a hard chancre is innoculated with great difficulty upon an individual already syphilized, and never or very rarely produces a similar sore; the resulting ulcer partakes more of the character of a soft chancre, but would be capable of reproducing its original form upon an individual free from previous taint.

Modification of the ordinary hard Chancre.

Sometimes the induration forms a very thin layer beneath the surface constituting the variety called by Ricord the parchment chancre; sometimes it is less regular than in the variety described above.

In women there is frequently no ulceration but only the formation of a hard papule, which is followed by the usual induration of the glands, but occasionally by no other constitutional symptoms. The question of the relation existing between the ulceration and the induration is one that has attracted much attention. Ricord denies that induration ever precedes ulceration, and states that in all cases of apparent exception, the breach of continuity has been overlooked; this is however completely at variance with the opinions of most authorities both in Germany and in this country, some of whom consider that the induration is the first stage, and that the process not unfrequently does not advance beyond it.

The existence of a period of incubation of the syphilitic virus is also denied by Ricord, who almost stands alone on this particular point. From the direct experiments of Von Bærensprung the period has been proved to be occasionally about 28 days in cases of innoculation; other writers give it as usually from 14 to 21 days, which is probably the ordinary time. It is important to remember that there is only a very short, if any, incubation period in the soft chancre.

Another fruitful ground of controversy is the period, to which the contagious principle of the syphilitic virus remains active. The primary chancre, its accompanying induration, and consequent bubo is admitted by all to be eminently contagious; most observers also now allow that the secretions from mucous tubercles can communicate the disease, and none can doubt the power of the semen to transmit the syphilitic constitution to the fœtus, in which latter the poison appears as a contagious principle. Beyond this point lies the debatable land, some authorities considering that the fluids of the body of a syphilitic individual—viz. blood, milk, secretions from secondary eruptions or inflammations, &c.—are capable of transmitting the disease when admitted by innoculation into the body of a healthy subject; others again, amongst whom Ricord stands pre-eminent, deny that any such power exists in these fluids or at any rate in the blood and milk. The evidence appears to be decidedly in favour of the possibility of transmitting the disease by the innoculation of the blood and some

of the fluids obtained from specific eruptions, but much probably depends upon the period which may have elapsed since the disappearance of the primary symptoms, and upon the evidence of the activity of the poison which still exists.

The following rough classification of the sources from which contagion may be suspected, will indicate the gradual decrease in the power of transmission of the disease as the case progresses.

1. Class. Transmit disease easily; very contagious.

Secretions from { Indurated chancre and papule. / Indurated Bubo. / Mucous Tubercles and Condylomata.

2. Class. Transmits disease easily to fœtus; doubtfully contagious.

Semen of infected parent.

3. Class. Transmits disease with some difficulty; observers differ on this subject, evidence in favour of contagion.

Blood and other fluids of Body.

Secretions from syphilitic eruptions and inflammations of Periosteum and Iris.

4. Class. Transmits disease with great difficulty, if at all: evidence in favour of no contagion.

Lymph from Vaccine Vesicle.

5. Class. Incapable of transmitting disease.

Necrosis and caries of Bone.

Serpiginous Ulcerations of Skin.

Disease of Muscle and Viscera.

Gummy Tumours.

Infantile Syphilis. Amongst the many points, which must be considered to be still sub-judice in this subject, the following may be especially pointed out as being worthy of investigation.

The questions whether a syphilitic child can infect a healthy nurse, when suckled by her, and whether a syphilitic nurse can infect a healthy child by suckling it, are most important.

Can an individual the subject of hereditary syphilis contract a true primary sore, and suffer from the effects of progressive syphilis?

Does any relation exist between hereditary syphilis, and the other forms of constitutional affections known under the names of the strumous, the tuberculous, and the rachitic?

To what extent are the children of parents the subjects of hereditary syphilis, affected by the constitutional taint?